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no.2
(1981
Jan.)

MEDICAID MEDICARE EXCHANGE

MEDICAID/MEDICARE CHANGES ENACTED

House and Senate conferees approved a number of Medicaid, Medicare, and PSRO provisions in December. The Omnibus Reconciliation Act of 1980 represents the most significant change since the 1972 Social Security Amendments were passed. The bill was signed into law (P.L. 96-499) on December 5. Some important provisions of that Act are:

- Effective July 1, 1981, there will be unlimited home health visits under Medicare Parts A and B; occupational therapy will be a benefit-qualifying service; the three day prior hospitalization requirement (Part A) will be eliminated along with the \$60 deductible for home health benefits under Part B.
- Medicare will be the second payor for services which can be reimbursed under automobile insurance, liability insurance, or no fault insurance. (Effective on enactment)
- Extends from 14 to 30 days the period during which a Medicare patient may be transferred from a hospital to a SNF and covered for extended care services. (Effective on enactment)
- Effective June 1, 1981, Medicaid pays for nurse/midwife services, if authorized under State law or regulation.
- Authorizes Federal matching payments for the State's cost in establishing and operating a qualified Medicaid Fraud Control Unit. Matching rate is ninety percent during first three years and 75 percent thereafter. (Effective on enactment)

Provisions previously excluded from the Reconciliation Bill were contained in H.R. 8406 which was signed into law (P.L. 96-611) December 28.

P.L. 96-611 allows States to continue AFDC (Aid to Families with Dependent Children) coverage for 18 to 21 year old students attending high school or undergoing vocational training. This law also has a transfer of assets provision which limits Medicaid and SSI eligibility for those who dispose of assets at less than fair market value. SSI applicants would have to count as assets any they have disposed of within the previous two years. In certain instances, States could establish transfer of assets rules different from those under SSI. It also provides Medicare coverage, effective July 1, 1981, for pneumococcal vaccine, a protection for the elderly against pneumonia.

THE DISTRICT OF COLUMBIA AWARDS MMIS CONTRACT

The District of Columbia's Medicaid Management Information System (MMIS) contract was awarded to The Computer Company (TCC) October 3. The contract calls for installation of the MMIS system by April 1981, with processing of all Medicaid claims to begin by July 1981. TCC will also be the District's fiscal agent for four years. TCC has similar contracts in Pennsylvania, Delaware, Virginia, and West Virginia within Region III. TCC commenced work on October 6.

This installation provides the District with its first fiscal agent and through it, provides the capability to screen out misuse and erroneous payments for medical services in that jurisdiction. In addition, the MMIS will improve the District's management and control functions of their Medicaid program.

The Health Care Financing Administration played a substantial role in writing the request for proposal (RFP) and the evaluation criteria, while providing extensive technical assistance in securing a contractor for this contract. For further details, contact Pat McCarthy, 301-594-3551, FTS 8-934-3551, or 202-727-3364.



NEW LEGISLATION ON MEDICAID MANAGEMENT
INFORMATION SYSTEM (MMIS)

On October 7, 1980, President Carter signed into law (Public Law 96-398), the Mental Health Systems Act which contains an amendment requiring most States to operate mechanized claims processing and information retrieval systems (MMIS) for their Medicaid programs. Under this amendment (proposed by Senator Schweiker), Federal Financial Participation (FFP) may be reduced if a State has not met these legislative provisions by the deadline, which is the earlier of: September 30, 1982, or six months following the date specified in a State's Advanced Planning Document (APD) for an operational MMIS.

Federal staff are required to review annually approved State MMIS systems, and may disapprove those which fail to meet standards. States disapproved would be subject to a reduction in FFP which would remain in effect until State actions were taken to correct the deficiencies.

Copies of this amendment are available from:

Health Care Financing Administration
Bureau of Program Operations
Office of Methods and Systems
Room G-20, East High Rise
6401 Security Boulevard
Baltimore, Maryland 21235
301-594-8441, FTS 8-934-8441

FEDERAL FINANCIAL PARTICIPATION UPDATE

The number of States approved for 75 percent Federal Financial Participation (FFP) for operation of a mechanized claims processing and information retrieval system continues to climb. The most recent States added to the list are Mississippi and Tennessee, bringing to 33 the total number of States receiving 75 percent FFP.

Five additional States are anticipating approval of 75 percent FFP for Fiscal Year 1981. Closest to approval among the five States is Maine, where a site visit has already taken place.

Seven States/Territories still have no active Federal MMIS plans, while one State and one Territory have no Medicaid program. For further information contact Richard Moss, 301-594-6491, FTS 8-934-6491, or Bea Smith, 301-594-8441, FTS 8-934-8441.

FIVE HMO DEMONSTRATIONS UNDERWAY

Five projects designed to increase Medicare and Medicaid enrollment in HMOs and promote cost effectiveness and competition in the health care marketplace are underway. Sponsored by HCFA's Office of Demonstrations and Evaluations, these demonstrations are intended to provide HHS with the opportunity to test the effects of alternative HMO risk reimbursement methods, which many believe would be better suited to HMOs than current cost-based approaches. In addition, to attract more Federal beneficiaries to join, the HMOs are required to return their savings to enrollees in the form of increased benefits and/or reduced cost sharing.

Each of the projects consists of two phases. During Phase I, the HMOs developed prospective risk reimbursement methodologies, designed marketing programs, and implemented the management systems required to ensure quality and interface with HCFA. Four of the five projects have entered Phase II, and, as of September 1980, a total of 15,600 Medicare beneficiaries were enrolled in three

of the HMOs: the Fallon Community Health Plan of Worcester, Massachusetts; the Marshfield Medical Foundation of Marshfield, Wisconsin; and Kaiser, in Portland, Oregon. Enrollment targets at these HMOs were easily met, probably due to their coupling of expanded benefits at less cost than the fee-for-service system. Indications that these projects are stimulating the competitive environment in their localities have begun to occur as Medicare patients become new members of these plans. The fourth project, in Minneapolis/St. Paul, Minnesota, is being conducted by InterStudy.

Enrollment will be initiated during the winter, 1981. Health Central of Lansing, Michigan, plans to begin open enrollment in the spring. Fallon is currently the only demonstration with a Medicaid contract; however, InterStudy, and Health Central have expressed interest in Medicaid contracting after gaining some experience with Medicare. Contact: Sidney Trieger, 301-594-8724, FTS 8-934-8724.

CAPITALIZING STATE RESOURCES

M/MMI's Corrective Action Projects Division (CAPD) provides technical assistance and professional consultative services to Medicaid State agencies. In response to the increasing level of concern about controlling program costs, CAPD is expanding its focus beyond operational problems in such areas as claims processing and third party liability. Later this year, the Exchange will publish a series of reports on new CAPD consultative services in restructuring benefit packages to assure the availability of the most needed services to the most needy population. Comments on how CAPD may better address State concerns in these areas are invited. Contact: Arthur Pergam, 301-594-8942, FTS 8-934-8942.

TITLE XIX/TITLE IV-D WORKSHOP

Representatives of the Medicaid and IV-D programs in Illinois, Indiana, Michigan, Ohio and Wisconsin attended a HCFA/OCSE workshop sponsored by Region V and the Corrective Action Projects Division, October 21. This joint workshop was held in the Chicago regional office and provided the States, HCFA and OCSE personnel with the opportunity to exchange information concerning the implementation of the new IPL regulations. The IPL regulations were discussed from both the Medicaid and IV-D perspectives.

Formal presentations at the workshop covered a wide range of activities which could assist States in either the developmental or advanced stage of cooperative efforts. The details of a study conducted in Wisconsin to determine the cost effectiveness of health insurance coverage on children were examined, along with the status of a study underway in Maryland to determine the administrative costs to the IV-D agency in carrying out certain task for Medicaid. The process and results of an experimental project which took place in Massachusetts were also reviewed. The Massachusetts project involved IV-D agencies providing an "absent parents" mailing list to Medicaid staff. This list will be used to send a health insurance questionnaire to the absent parents. Presenters discussed the problems encountered and lessons

learned in implementing these various projects, sharing their insight and providing guidance to workshop participants.

The Chicago workshop is the prototype of a series of workshops being planned for other regional offices. Contact: Jane Herlocker, 301-594-9511, FTS 8-934-9511.

DELAWARE ERROR PRONE PROFILING

The Corrective Action Projects Division recently generated and analyzed error prone profiles for the State of Delaware. The results of the analysis showed that 75 percent of all errors in the State are agency caused errors. Of this total, 44 percent are directly related to policy problems. The profile identified pensions and other personal property as having the highest probability of error, with several associated characteristics also indicated.

In its report to the State, CAPD enumerated the administrative screening process for review of error prone cases and recommended specific corrective actions. Major corrective actions included conducting more intensive reviews of error prone cases, followup of potential resources - reviewing policy from the "prudent person" concept; and the review of agency controls for monitoring potential resources, making use of automated data processing where possible. Contact: Ellen McNeill, 301-594-9513, FTS 8-934-9513.

MEDICARE CONTRACTORS' CONFERENCE POSTPONED

The Medicare Contractors' Conference (MCC) originally scheduled for March 3-4, 1981, in Cincinnati, Ohio, has been postponed until later in 1981.

As a new Administration will be taking office in January, officials of the Bureau of Program Operations and the co-chairpersons of the Fiscal Intermediary Group and the Carrier Representative Group agreed that March would be too early to have a sense of direction the incoming Administration would pursue regarding health care programs. Accordingly, the MCC will be rescheduled for a time not only when that direction has become clear, but also when senior Administration officials will have been selected and can be invited to address the contractors.

In the meantime, a work group has been designated to begin planning for the conference. Merritt Jacoby and Ben Patterson, FIG co-chairpersons, will represent Part A contractors; Chuck Stewart and Steve Abramson, CRG co-chairpersons, will represent Part B contractors. Representing HCFA will be Doris Soderberg and Will Wolstein, of BPO's Medicaid/Medicare Management Institute.

1634 AGREEMENT FOR MISSISSIPPI

The Mississippi legislature has mandated that the Mississippi Medicaid Commission enter into a 1634 agreement with the Social Security Administration by July 1, 1981.

Under a 1634 agreement, the State would begin using Supplemental Security Income standards as the basis for Medicaid eligibility for their aged, blind, and disabled recipients. Mississippi now uses State standards in determining Medicaid eligibility.

Changing to SSI standards is expected to add approximately 15,000 recipients to the State's Medicaid rolls. The cost for additional eligibles is expected to be balanced by administrative cost savings made possible through the SSA assumption of eligibility determinations.

Presently, Mississippi is reviewing several systems designs furnished to them by the Medicaid and SSA regional offices, to determine which will most effectively process SDX, BENDEX, and State Buy-in files. For further information, contact Glenn Smith, Region IV, 404-221-2044, FTS 8-242-2044.

PROUD OF YOUR WORK?



SHARE IT

CATALOGUE OF STATE MATERIALS

The 1981 edition of the Catalogue of State Materials is scheduled for printing in May. The Catalogue serves as a means of exchanging Medicaid program information among State agencies. If your State has published a manual, report, publications on State practices, pamphlets, etc., that you would like to share, send them to the M/MMI for inclusion in our next Catalogue. Include a contact person and phone number, and send to:

Carlotta Wilkins
HCFA, M/MMI Clearinghouse
389 East High Rise
6401 Security Blvd.
Baltimore, MD 21235

Trainers...Take Note!

Shortstaffed? Want a few good "canned" programs that would free you to concentrate on other training programs? Trainers Take Note has just the idea for you. Develop your own audio-visual presentations.

Slide shows are ideal for simple messages. They can be tailored exactly to your need, whether it be familiarizing new employees with the organization and its leaders, presenting an overview of a program, or describing a relatively simple process, e.g., explaining how claims are processed, or how a manual is referenced. As a matter of fact, this article was sparked by viewing a slide show produced by Blue Cross of New Jersey.

Slide shows are fun to make. Trainees find them instructive and enjoyable to use. Best of all, you can produce a slide show for under \$15 in materials! How do you do it? There are seven easy steps:

1. Buy: 1 or 2 rolls of 35mm slide film. Quantity depends on the number of slides needed.
 1 blank audio-cassette.
2. Find: 1 audio-cassette tape recorder preferably with inaudible impulse recording capability (sync pulse feature).
 1 person with fine recording voice.
 1 35mm camera buff on the staff.
 1 35mm slide projector with sync pulse feature.
3. Develop: a 5-10 minute script on a given subject. Include descriptions of graphics or photos which would be needed to illustrate the script -- make sure you clear script with higher authorities as you go along.
4. Contact supervisors for permission to photograph staff at work, equipment, or other essential onsite scenes.
5. Photograph illustrative scenes and graphics.
6. Assemble photos and graphics with polished script -- 15-20 seconds of narration per slide is ideal.
7. Tape script and program inaudible impulses for slide changes. If this feature is not available on your machine, the conventional beep tone will suffice.

And, PRESTO! A fine instructional package that can be used hundreds of times. All for a little money and a few days of staff time.

Susan Eberhard and Wayne Gegorek



STUDENTS AVAILABLE FOR ADMINISTRATIVE RESIDENCIES

Graduate students preparing for careers in health administration are available for administrative residencies with Medicaid State agencies and for Medicare contractors.

These students, being trained in member institutions of the Association of University Programs in Health Administration (AUPHA), are interested in job related experience in the health care field, specifically in the area of reimbursement for health services. Depending on the requirements of specific universities, administrative residencies for students may range in length from three months to a year. The shorter residencies commonly occur over the summer months and are most often project oriented, with students researching some aspect or activity of the hiring organization. Longer residencies, those ranging from nine to twelve months, provide sufficient time for students to accept more job-oriented responsibilities.

In the past, both preceptor organizations and students have found residencies rewarding, with value from the student's work accruing to employing organizations and student benefiting from both the observation of, and work in, a non-academic setting.

For the period of the residency, students are usually awarded a stipend by the employing organization. This stipend is negotiable between the student and that organization.

For further information about the availability of students for administrative residencies, please contact: Charles N. Kahn, III, Association of University Programs In Health Administration (AUPHA), Director of the Office of Financial Management Education, One Dupont Circle - Suite 420, Washington, D.C., 20036.

CASE STUDY OF MINNESOTA'S RESTRICTED RECIPIENT PROGRAM

Minnesota's lock-in program is the subject of a recent case study by a health consultant firm entitled "Case Study and Analysis of the Minnesota Medical Assistance Recipient Restriction Program", published in Pracon Inc.'s Management Applications series.

The article lists the program's primary objectives as improving the quality and continuity of medical care for participating recipients, and controlling Medicaid expenditures. The article describes the effects of a restriction program on the utilization of medical services and expenditures. Several charts are included showing the average decrease in service utilization; the expenditure percentage distribution from before, during, and after restriction; the average decrease in expenditures, and the estimated cost savings.

Under a lock-in or restricted recipient program, the recipient selects a single primary physician, pharmacy, and/or other provider for services.

Minnesota services approximately 200,000 recipients with an average monthly utilization rate of 135,000. The lock-in program began in 1976, with 178 recipients participating since that time.

Average net savings per recipient ranged from about \$4,400 to \$5,000 during a two year period, a savings of \$1.38 to \$2.59 for each dollar invested in the lock-in program.

Requests for Section IV Special Reports or other issues of Management Applications may be directed to Hoffman-LaRoche, Inc., Medicaid Resource Center, Building One, Room 327-A, Nutley, NJ 07110.

CHILD HEALTH CHECKUP

EARLY AND PERIODIC SCREENING, DIAGNOSIS

AND TREATMENT SUBSYSTEM DEVELOPMENT



An eighteen month contract has been awarded by HCFA's Office of Child Health to develop an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) subsystem for California's Medicaid Management Information System (MMIS). The contractor has completed a local assessment of information flow in Contra Costa, Fresno, and Los Angeles counties. From this analysis of county operations, together with a thorough study of program functions at the State level, the contractor will develop alternative approaches to an automated system design. An advanced planning document, implementation guide, and user's manual will be created for the accepted alternative. The State of California will implement the design, becoming the first State to have incorporated an EPSDT subsystem within the guidelines of the MMIS General Systems Design. The California product will be generalized to a transferrable prototype that will be made available to all States with county operated and administered EPSDT programs. Contact Pat Hotkowski in the Office of Child Health for details at 301-597-1878, FTS 8-987-1878.



INTER-STATE TECHNICAL ASSISTANCE

A recent arrangement between the States of Idaho and Alaska might prove to be a model for providing cost-efficient technical assistance to alleviate specific program needs at the State and/or local level.

In August 1979, Alaska's Department of Health requested regional office assistance in obtaining an expert to help revise their EPSDT manuals. This project had been continually postponed by the State because of funding restrictions. The manual revision was necessary to reflect the changes which had occurred in Medicaid EPSDT regulation and were scheduled to go into effect in October.

Bill Collins, the Region X EPSDT Coordinator, through his familiarity with the various State operations in his region, felt that Bill Overton, the EPSDT Program Coordinator in Idaho could provide the expertise that

Alaska required. Overton had to operate under similar fiscal constraints in Idaho, and was familiar with the problems presented by a widely dispersed Medicaid eligible population. More importantly, Overton had written the most recent update of Idaho's EPSDT manual. Collins' problem was how to arrange Overton's transfer to the satisfaction of all parties involved.

Through the cooperative efforts of the respective States, the regional office, and the Office of Child Health, the transfer of Overton to Alaska and the subsequent revision of the EPSDT manual was accomplished. With the regional office coordinating the effort, Idaho granted Overton a leave of absence, the Office of Child Health paid his travel expenses, and Alaska paid his salary. Contact for further details is Bob Pagelsen in the Office of Child Health at 301-597-1886, FTS 8-987-1886.

CHILD HEALTH VIDEO TEST TAPE UNDER DEVELOPMENT

The Office of Child Health, with the Office of Public Affairs, is developing a test tape containing regional and State television tapes promoting EPSDT and positive child health care. The test tape is intended to provide guidance to regions and States in production of EPSDT and child health television promotions. Among the "spots" that will be included are:

Region VI - Videotapes featuring Dallas Cowboy football player Tony Hill promoting child health and EPSDT, will shortly be released. Produced by the Dallas regional office with the cooperation of a local television station, the 30 and 60 second tapes will be distributed throughout Region VI States.

Region VII - Willie Wilson of the Kansas City Royals baseball team is the star of videotapes urging regular medical checkups for children. The tapes, produced by the Kansas City regional office, were discussed in greater detail in issue #6 of the Medicaid/Medicare Exchange.

Region IX - Lou Ferrigno, who portrays the Incredible Hulk on television, informs children and their parents of the importance of good health practices and of the services of the California Child Health and Disability Prevention Program. Ferrigno's participation is notable because he was the victim of a childhood disease which left him partially deaf. The spot was produced by Los Angeles county.

Region X - The State of Alaska has produced a winter and a summer version of videotapes promoting good child health practices and EPSDT. The tapes show children engaging in seasonal sports activity with the health message being delivered by voiceover.

The Seattle Regional Office, with the assistance of a local television station, has produced a videotape featuring Bill Gregory of the Seattle Seahawk football team. In the tape, Gregory and a group of youngsters promote good health care for children and the local "Check-It-Out" campaign.

For further details about these test tapes, contact Bill Collins, FIS 399-0506.

SCHOOL SYSTEM PARTICIPATION IN EPSDT

An EPSDT provider agreement was recently signed by the Minneapolis Public Schools and Minnesota Department of Public Welfare. This was the first instance in Region V of a school system participating in EPSDT since the announcement of HCFA's interagency initiative to bring schools into EPSDT.

The agreement provides for implementation of a pilot project in two Minneapolis elementary schools during the 1980-81 school year. The two schools contain approximately 1250 children on medical assistance. Only children on medical assistance who have not had EPSDT services within the past three years will be eligible for inclusion in the project. Screening will be performed in the schools by school nurses.

The project's purpose is to explore the feasibility of using the schools as a provider of EPSDT services for children who have not been reached by traditional program outreach methods. The schools will identify the hard-to-reach children, encourage their participation in the program, and attempt to link them to a system of ongoing health care.

Contact: Jonathan Nachsin at 312-353-3702 or FIS 353-3702 for further information.

ACTION TRANSMITTALS

These Action Transmittals have been issued by HCFA in November. States desiring copies may order them by calling 301-594-5119, FTS 8-934-5119.

- AT-80-80 Policy Clarification
Medicaid/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Interrelationships with State Maternal and Child Health (MCH) Programs (refer to 42 CFR 431.615 and 42 CFR 441.55)
- AT-80-81 Third Party Resource Workshop - HCFA-301C, Effective: The Medicaid Quality Control Sampling Period Beginning October 1980 (refer to Medicaid Quality Control Manual, Chapter 3400 and 42 CFR 431.800)
- AT-80-82 Medicaid Quality Control Third Party Liability Review (refer to 42 CFR 431.800)

INFORMATION MEMORANDUMS

The following Information Memorandums recently issued by HCFA are also available to States by calling 301-594-5119, FTS 8-934-5119.

- IM-80-27 Improving Consistency, Accuracy and Comparability of Diagnosis and Procedure Labeling System
- IM-80-28 Third Party Multi-State Workshop
- IM-80-29 List of Single State Agency Directors and Medical Assistance Unit Directors
- IM-80-30 EPSDT Quality Control Requirement for Cases Where the AFDC Payment has been Held or Suspended
- IM-80-31 Overview of the Federal Approvals Process for State Medicaid Management Information Systems
- IM-80-32 EPSDT Quality Control Reviews of Recipients Due for Rescreening When the Period Ends at Age 21
- IM-80-33 State Medicaid Directors' Mid-Year Conference
- IM-80-34 Third Party Liability Workshops
- IM-80-35 Implementation of the Common Claim Form - HCFA-1500

MMMI EVENTS

Third Party Liability Workshops
Jan. 7-8, 1981 St. Louis, MO
Jan. 20-21, 1981 St. Louis, MO

Contact: Du'Va Clyburn
301-594-8648
FTS-934-8648

Carrier Representative Group Meeting
Feb. 6, 1981 Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS-934-9455

EPSDT National Conference
March 17-19, 1981 Denver, CO

Contact: Joyce Sutton Zutell
301-594-8945
FTS-934-8945

PSRO Workshops
March 24-26, 1981 Baltimore, MD
April 28-30, 1981 Kansas City, MO
May 19-21, 1981 San Diego, CA

Contact: Beulah Williamson
301-594-8647
FTS-934-8647

IPR/MR Teams Training Workshop
May 5-7, 1981 Philadelphia, PA

Contact: Beulah Williamson
301-594-8647
FTS-934-8647

Watch this space for announcements of additional programs.

REGULATIONS EXPAND CERTIFICATE OF NEED PROGRAMS

On October 21, HHS issued final regulations expanding State certificate of need programs. The regulations require health facilities to obtain State certificates for major capital expenditures, proposed additions, or termination of services, which cost more than \$75,000 a year to operate. A certificate of need is also required for all important changes in bed capacity and for the purchase of hospital inpatient equipment costing more than \$150,000.

The new regulations expand HMO certificate of need exemptions and also require health planning agencies to consider the effect of competition on the supply of the type of health services under review. For the first time, the regulations provide that any person directly affected by a certificate of need decision be offered an administrative review, or they may request a judicial review. States are required to set an expenditure limit on each certificate of need issued.

States and territories with certificate of need programs approved by HHS may need to make changes by January 1982, in order to comply with the revised regulations. For further information contact Health Resource Administration, 301-436-6140.

HOSPITAL COST REPORT INFORMATION SYSTEM OVERVIEW

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) has awarded a contract to Morris, Davis and Company and Applied Management Sciences, Inc., to develop and demonstrate the feasibility of establishing a Hospital Cost Report Information System.

The contract objectives are to establish and test an automated central data collection, processing and distribution system for hospital cost report data. This system would be required to: accept hospital cost report data (HCFA 2552 Revised) from Fiscal Intermediaries for all certified hospitals on a monthly basis; edit and reconcile inconsistencies; construct a data base suitable for analytic and monitoring activities; and provide different subsets of these data to various HCFA components.

The contractor will develop a demonstration system that will be capable of accepting hospital cost report data in both hard copy and magnetic tape format from all Fiscal Intermediaries (FIs). The data provided by the FIs will cover all Medicare certified hospitals in the United States. The hospital cost report data will be furnished at three points in the cost settlement process. The first point is the "as submitted" hospital data after it first clears edit in the Automated Desk Review (ADR) but prior to professional review. (Non-ADR intermediaries will identify a similar point for tape creation.) The second submission of data will take place after audit adjustments have been made and final settlement has taken place. The third submission will be necessary in those instances where a cost report is reopened after final settlement.

Essentially all of the data submitted to the contractor in the process of the demonstration will be on magnetic tape. The majority of these tapes will be by-products of Automated Desk Review Systems. The ADR is a generic software package developed by several vendors to generate a complete Medicare Cost Report from a minimal set of entries. The ADR verifies the arithmetic performed as well as performing numerous other checks. The information submitted on the tapes will contain identification of the ADR that produced it, if any. The contractor must work closely with the Blue Cross Association, Health Insurance Association of America, other representatives, FIs, and with ADR vendors so that the demonstration system will be fully consistent with FI/ADR submissions. Contact: Melvin Gent, 301-597-2383, FIS 8-987-2383.

Personnel

HCFA CENTRAL OFFICE CHANGES

Martin L. Kappert - Director,
Bureau of Quality Control

Penni St. Hilaire - Acting
Director, Division of Long
Term Care

MEDICAID

Rebecca Beasley - Alabama's
Acting Commissioner

CORRECTION

Richard A. Chevretils -
New Hampshire's Single
State Agency Director

Lawrence Ford - New
Hampshire's Medical
Assistance Unit Director



MORE NEWS

BPO's TRAINING IN EVALUATING CONTRACTOR PERFORMANCE

Effective October 1, 1979, HCFA began evaluating Part A intermediaries' performance against criteria and statistical standards developed by the Bureau of Program Operations. Similar performance criteria and statistical standards were developed for Part B carriers effective October 1, 1980. HCFA regional offices apply the criteria in evaluating contractor performance, and central office accumulates and publishes cost, bill processing and cost report settlement timeliness data.

BPO conducted a training session in Baltimore, October 28-31, for regional office personnel. The training consisted of presentations describing revisions in the Part A criteria and standards for FY 81, the new Part B criteria and standards, as well as improvements made in sampling and scoring techniques. The attendees included regional office staff from Program Operations and Program Integrity. Approximately 60 regional office staff participated in the training. These attendees will, in turn, train other regional office personnel who will be involved in contractor performance evaluation. They will also conduct orientation sessions for their contractors who use the criteria and standards to monitor their individual operations on an ongoing basis. For further information, contact Myron Bates, 301-594-8504, FTS 8-934-8504.

PROVIDING MEDICARE CLAIMS INFORMATION TO MEDICAID AGENCIES

A revised policy affecting the transfer of Medicare claims information to Medicaid agencies is provided in Medicaid Action Transmittal 80-70, Regional Medicaid Letter 80-35, and Regional Medicare Letter 80-44. The new policy will change or eliminate charges to State agencies for Medicare data.

Effective October 1, 1980, Medicare contractors will furnish Medicare billing/claims information to State agencies or their fiscal agents for Medicaid purposes. Upon request of the State, information will be released at no charge if provided in the Medicare tape format. Medicare information will be released to Medicaid only for those recipients with both Medicare and Medicaid coverage.

For further information concerning this policy, contact Don Posen 301-594-6224. To obtain a copy of AT 80-70 or RL 80-35 call 301-594-5519, FTS 934-5519.

MEDICAID QUALITY CONTROL MEETING

HCFA's Bureau of Quality Control held its quarterly Medicaid Quality Control (MQC) meeting in Baltimore, October 29.

Regional Assessments Branch chiefs, representatives from regional MQC staff and members from the central office attended. The purpose of the meeting was to help formulate national MQC policy and to generate a common understanding of national policy among the regional MQC staffs. Agenda items included revised 221 review procedures, additional training on a spenddown policy, and general management issues. Central office staff will utilize the regional input in developing MQC policies and procedures. Contact: Jeannette Keenan, 301-597-1308, FTS 8-987-1308.

REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Medicare Program: Reimbursement for Costs Incurred in Relation to Union Activities - Proposed Notice

10/21/80 Federal Register

Contact: William Goeller, 301-597-1802

Medicaid Program: Medicaid Quality Control; Time Requirements for Reviews; Technical Amendments - Proposed Rule

10/24/80 Federal Register

Contact: Carlton Stockton, 301-597-1350

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board Final Maximum Allowable Cost Determinations - Final Regulation

10/24/80 Federal Register - Effective 12/08/80

Contact: Charles Spalding, 301-594-5403

Medicare Program: Exclusion From Medicare Coverage of Bilateral Carotid Body Resection to Relieve Pulmonary Distress - Final Notice

10/28/80 Federal Register - Effective 10/28/80

Contact: Henry J. Hehir, 301-594-8561

Medicaid Program: Deeming of Income Between Spouses - Proposed Rule

10/30/80 Federal Register

Contact: Dennis McNow, 301-594-8221

Medicare Program: Qualifying Conditions and Reimbursement of Health Care Prepayment Plans - Proposed Rule

10/31/80 Federal Register

Contact: Frank Emerson, 301-594-8221

Medicaid and Medicare Programs: Approvals, Extensions, and Corrections of Incorporations by Reference - Final Rule

10/31/80 Federal Register

Contact: Rose Anne Lawson, 202-523-4534

Medicaid and Medicare Programs: Regional Reorganization; Statement of Organization Functions and Delegations of Authority - Notice

10/31/80 Federal Register

Contact: Regional office representative

Medicaid and Medicare Programs: Health Care Financing Administration Privacy Act of 1974; Report of New Routine Use

11/06/80 Federal Register - Effective 12/08/80

Contact: Castomal Alexander, 301-594-9882

Medicaid Program: Clinical Laboratories, Quality Control Standards Regarding Alpha-Fetoprotein Test Kits - Proposed Rule

11/07/80 Federal Register

Contact: Dr. Joseph H. Boutwell, 404-329-3263 or FTS 236-3263

REVIEW

Medicaid Program: Clinical Laboratories; Personnel Standards - Withdrawal of Proposed Rule

11/07/80 Federal Register - Effective 11/07/80

Contact: Dr. Louis C. LaMotte, 404-329-3824 or FTS 236-3824

Medicaid and Medicare Programs: Reimbursement for Services Furnished by Rural Health Clinics; Extension of Comment Period - General Notice

11/07/80 Federal Register - Comments Due 12/10/80

Contact: William Bake, 301-597-2953

Medicaid Program: Health Financing Research and Demonstration Grants; Special Solicitation; Alcoholism Services - Final Notice

11/07/80 Federal Register - Closing Date: All grant applications must be received by 4:30 p.m., January 15, 1981

Contact: Dr. Andrew Solarz, 301-594-0397

Medicare Program: Definitions and Reimbursement of Hospital Intensive Care Type Units - Correction Notice

11/07/80 Federal Register - Effective 10/01/80

Contact: Alton Cobb, 301-594-9773

Medicare Program: Technical Amendments on Reconsideration and Appeals Under the Hospital Insurance Program - Final Regulation

11/07/80 Federal Register - Effective 12/08/80

Contact: Jack Wasserman, 301-594-9300

Medicare Program: Validation of Accreditation Surveys of Hospitals - Final Regulation

11/12/80 Federal Register - Effective 12/12/80

Contact: Janet Harryman, 301-594-9714

Medicaid and Medicare Programs: Reimbursement for Services Furnished by Rural Health Clinics; Correction - Proposed Rule Correction

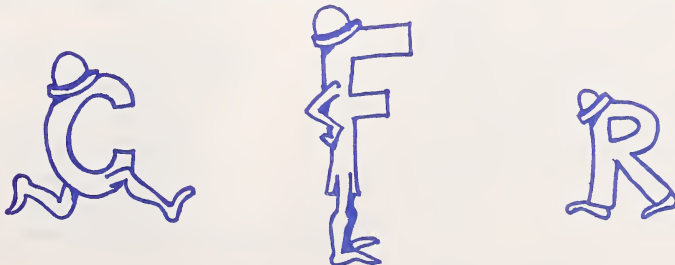
11/14/80 Federal Register

Contact: George Morey, 301-594-9779

Medicaid Program: Debarment and Suspension from Eligibility for Financial Assistance; Correction - Final Rule Correction

11/24/80 Federal Register

Contact: William Kettener, 301-496-6043





ADULT DAY CARE DIRECTORY

HCFA's Health Standards and Quality Bureau has published a Directory of Adult Day Care Centers. The directory lists facilities in each State that provide adult day care services and programs designed only for the geriatric population. Senior center programs and facilities that provide psychiatric or mental health services for adults of all ages and the mentally retarded are not included.

This is an updated directory of the 1978 publication (the first directory of its kind), and represents the only national compilation of adult day care programs currently available. A list is included of 120 programs in nine States that reimburse for day care services through Medicaid.

Each center listed includes the name, address, and telephone number of the facility; along with the program director, starting date, sponsoring organization, funding source(s), the nature of the program (restorative/maintenance, or social) and the average daily census.

To obtain a copy of the directory at no cost, contact Ruth Perry of the Medicaid/Medicare Management Institute at 301-594-8856, FTS 8-934-8856.

COMBINED MEDICAID/MEDICARE SYSTEM SPEEDS CLAIMS PROCESSING

Medicaid and Medicare beneficiaries have the claims for their medical care processed more frequently as a result of a new computer system that combines processing of Medicaid claims with Part A and Part B Medicare claims.

This innovation is now possible because New Hampshire-Vermont Blue Cross/Blue Shield is the fiscal agent for the Medicaid program in Vermont as well as the Medicare carrier and intermediary for both Northern New England States.

Before the new computer system was implemented in September, the separate Medicaid system was run twice weekly, the separate Medicare Part A system was run twice weekly, and the separate Medicare Part B system was run three times a week. According to Jim Morrison, Manager of Government Systems at New Hampshire-Vermont Blue Cross/Blue Shield, "The number of claims processed in the separate systems did not justify more frequent computer runs."

The larger number of claims processed in the combined system, between 20,000

and 40,000, justified four computer runs a week. For further information contact Stanton Collins, Regional Medicare Director, 617-223-6804, FTS 8-223-6804.

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